United States Senate
WASHINGTON, DC 20510

June 30, 2010

General Eric Shinseki
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, Northwest
Washington, DC 20420

Dear Secretary Shinseki:

Please note our deep disappointment and concern that 1,812 St. Louis area veterans were potentially exposed between February 2009 and March 2010 to dangerous blood-borne diseases, including Hepatitis B and C and HIV, through possible contact with improperly cleaned dental devices at the John Cochran VA Medical Center (VAMC) in St. Louis, Missouri. In light of other recent revelations by the VA Inspector General regarding problems with reprocessing of endoscopes at John Cochran and frequent customer service satisfaction problems reported at John Cochran, we are concerned about VA management of the facility. Veterans receiving care at John Cochran deserve the best quality care available, including absolute assuredness that the hospital is meeting the most basic and critical professional standards of cleanliness and conduct.

We are also deeply concerned that the VA took four months to notify veterans who may have been endangered by the flawed procedures at the John Cochran VAMC, as well as to notify the area Congressional delegation so that we might assist our constituents. We appreciate that the VA acted quickly to remedy the flawed cleaning procedures but the failure to share information in a timely fashion about the situation is unacceptable. In addition, a follow up visit to John Cochran by VA Headquarters staff was not conducted until May, some two months after the initial inspection revealed problems with the cleaning of the dental devices. When a significant failure in procedures occurs, like that discovered at the John Cochran VAMC dental clinic, we would expect a more timely response and more aggressive oversight.

The VA has decided to dedicate $5 million in funding to make infrastructure and other improvements at the John Cochran VAMC in light of this troubling incident. While we applaud the VA's efforts to address aggressively underlying problems, including infrastructure problems that could have contributed to the failures in the dental clinic, we must be kept apprised of how the $5 million in renovations will be spent and prioritized. Please keep us informed about any follow up actions that the VA takes to train staff and improve standard operating procedures in the dental clinic and elsewhere in the hospital.

In closing, as you evaluate each of the 1,812 veterans who have received letters from the VA about potential exposure from improperly handled dental devices, we ask for an accounting of any health irregularities identified and attributed to the exposure. We know you value the health and safety of each and every veteran and strongly urge you to make sure that no veteran's health goes unchecked in this case. We are committed to working with you, Mr. Secretary, to provide veterans with the resources they need to heal—resources they earned through their great service. The repeated failures to follow simple rules and regulations, however, is wholly unacceptable, and we want to know the measures you plan to implement in order to ensure this catastrophe never happens again.

We thank you for your immediate attention to this matter and look forward to your reply. Should you have additional questions please feel free to contact us directly or to have your staff contact Tressa Guenov in Senator McCaskill's office, Bo Prosch in Senator Bond's office or Gabe Chavez in Senator Durbin's office.

Sincerely,

Claire McCaskill
UNITED STATES SENATOR

Christopher Bond
UNITED STATES SENATOR

Richard Durbin
UNITES STATES SENATOR